

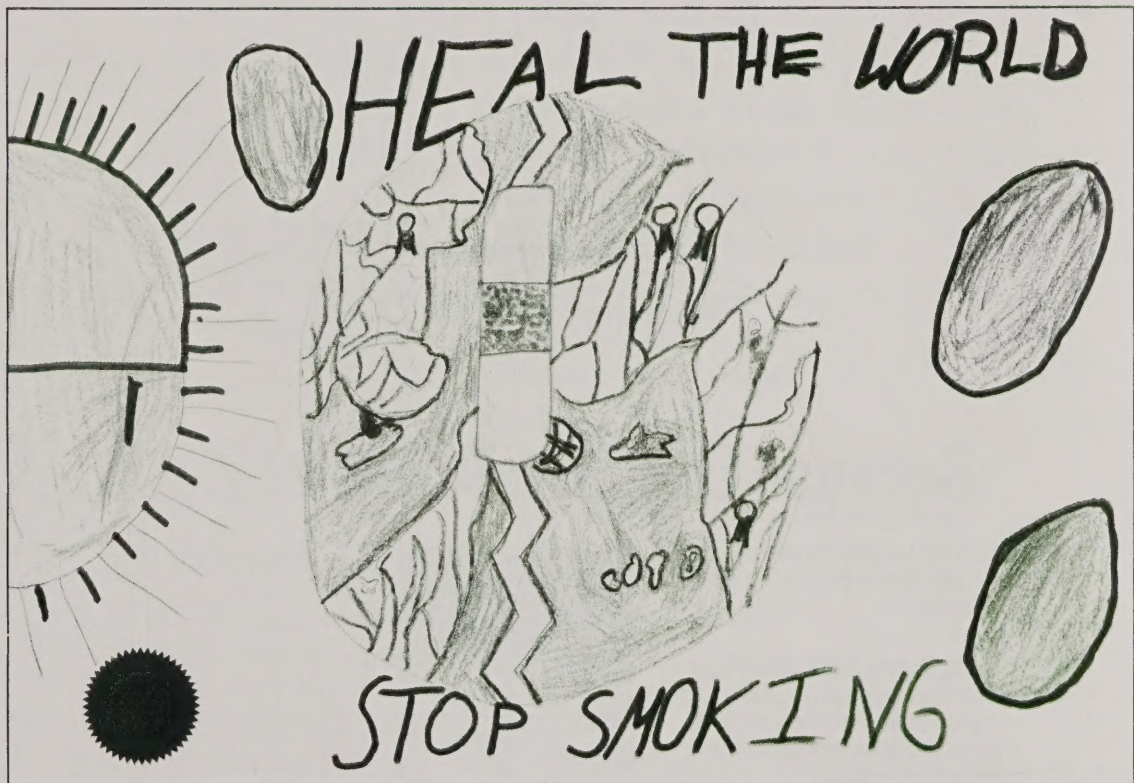
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THE
**Hampden
Hippocrat**
JULY—AUGUST 1993

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The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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HAMPDEN DISTRICT MEDICAL SOCIETY 1993-1994 SEASON

DISTRICT MEETING

PLACE: THE DELANEY HOUSE
Route 5 at Smith's Ferry
Holyoke, MA 01040

DATE: Tuesday, September 28, 1993

BUSINESS MEETING: 6:00 p.m.

SOCIAL HOUR: 7:00 p.m.

DINNER: 7:30 p.m., SPOUSES ARE WELCOME!

SPEAKER: GREGORY CONNOLLY, D.M.D., DIRECTOR
Office on Non-smoking and Health
Massachusetts Department of Public Health

NOTE: If you must cancel your dinner reservation, please call the HDMS office before noon on September 28th. If the cancellation is not made, you will be BILLED for your dinner.

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From the Editors

This issue is devoted to family medicine. The so-called "general physician" is historically very difficult to define. The generalist in Great Britain cares for all manner of ailments in all the people assigned to him/her. He/she never sets foot in a hospital. The "barefoot doctor" of China is trained to render first aid and do triage. At the other extreme are "Med-Peds" physicians who hold specialty boards in both Medicine and Pediatrics. The Internist, the Family Practitioner, and the generally trained Ob/Gyn physician also render general medical care.

The tension is further complicated by the advent of physician's assistants and nurse practitioners, who in some areas of the country are difficult to distinguish in practice from physician generalists.

In the future, will the role of the generalist be increasingly taken over by physicians with three or four years of post-graduate training who must undergo re-certification every five to ten years, or by individuals who train for four years after high school before entering the field under the presumed supervision of a physician?

This is not a merely academic debate, and the outcome will have profound social and economic implications. ■

Brigid Glackin, M.D.
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Are Larger Organizations Better— Or Just Different?

One proposed scenerio for health reform involves large blocks of small businesses, individuals or other groups forming regional coalitions with great economic power asking for proposals from provider groups—"accountable health plans"—with the best deal winning.



Francis D. Horrigan, M.D., President

If the so called accountable health plans are to market themselves to provider—brokers they need to prove they can deliver an array of quality health services in a cost effective manner. Implicit in this arrangement is the need to have current information systems to generate the necessary documentation of utilization and quality assurance performance. Very few individual physicians or even moderate-sized groups have both the array of necessary services or the sophisticated information systems needed to have any negotiating strength with providers. A result is that physicians, by choice or by necessity, will be forced to form relationships

outside their practices or risk losing blocks of patients through deals in which they had no control.

Physicians are a diverse group in terms of practice situations, experiences, cultural backgrounds and personal/professional goals. It is, therefore, no surprise that relationships offer opportunities nearly as diverse as the interests to be considered. Some physicians with limited practice goals e.g. those planning retirement or non practice activity may be able to do so without these new arrangements. Other favorably located, uniquely skilled subspecialist may be able to negotiate one on one with providers. Most physicians will find it necessary to be part of larger organizations in order to secure the best contracts.

Physicians are trained to analyze and solve problems while accepting unique responsibility for the process and outcome. One effect of this training and experience is to imbue physicians with a strong sense of autonomy which over time becomes difficult to dilute into larger group efforts. Additional pressures on more recently trained physicians result from the high debt load involved in financing medical education and the reluctance to further increase that debt load by trying to start up a practice unilaterally. Changing cultural mores and life style expectations also effect professional goals. The social effect of these changes is showing that younger physicians are tending towards larger groups or salaried situations. While there may have been a common profile of the "average physician" a few decades ago, physicians are now an evolving and increasingly diverse group.

Hospitals have pressures increasing on them also. Clearly inpatient activity as we know it will be decreasing. However this activity will not totally disappear any time soon. The

hospital in the community must adapt or close. The adaptation can be to evolve into a tertiary facility to serve large markets, to specialize for particular markets or to diversify—utilizing their resources to access and control a variety of services—ambulatory care and surgery, women's health, rehabilitation, psychiatry, home care, long term care or hospice. Accomplishment of these goals involves the cooperation of a range of health professionals including (especially) physicians. The present private practice model affords the opportunity for a wide array of physician hospital linkages. Physicians may wish to form groups themselves (IPA's) to negotiate with providers directly. The groups may become formal entities as single or multispecialty groups to deal with more than one plan or more than one hospital. Physicians may wish to be part of a practice in a hospital affiliated health system, be affiliated in a group practice without walls or merely affiliate to access management services.

All of these pressures and linkages ultimately tend to the formation of large groups of providers producing nearly uniform services. This has some advantages, mainly economic, and will help establishing minimal standards of care. Not to be lost in this equation is the richness of experiences, training and culture that the diversity of our present generation of physicians provide. Physician organizations must be continuously active to bring all the advantages of our individual physicians to bear on our national health/wellness agenda. This means we must be vigilant against a potential flip side problem to large health plans—lack of physician access—because no one cares enough to help everyone that wants to participate as much as he or she wants to. As always we must work together. ■

In Memoriam

Allen S. Johnson, M.D., passed away on April 17, 1993. Dr. Johnson, a graduate of Yale University, was president of the Massachusetts Medical Society in 1963, and served on several committees of the Society. His wife, Elizabeth, died in 1988. He leaves two daughters.

John Pallo, M.D., passed away on May 30, 1993. Dr. Pallo, a graduate of Harvard Medical School, was past president of Noble Hospital Medical Staff, and a member of the District and State Medical Society. He leaves his wife, Ida.

Milton H. Teitel, M.D., passed away June 7, 1993, in West Palm Beach. He graduated from the College of Physicians and Surgeons in Boston. He leaves a son and a daughter.

Walter Nero, M.D., passed away June 16, 1993. A graduate of Yale University School of Medicine, he was Chief of Surgery at the former Wesson Memorial Hospital, and served as Chief of Surgery at the Army General Command College in Fort Leavenworth, Kansas, prior to World War II. He leaves his wife, Anette, and a son. ■

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A New Model For Prenatal Care: The Holyoke Experience

The Hippocrat has previously reported on the crisis in infant mortality in the City of Springfield. This article describes the development of the Prenatal Center in Holyoke as a response to the high infant mortality rate there.

From 1977-1981, the City of Holyoke had the highest infant mortality rate in the Commonwealth of Massachusetts (16.3/1000 live births). By 1990, the city's rate was cut nearly in half (8.9), approaching the rate for the State as a whole (7.0). Much of the credit for this dramatic improvement can be taken by the Holyoke Infant Mortality Task Force, formed in 1984. The history of the Task Force and its ongoing legacy are the topic of this presentation.

Setting And Population

Holyoke, Massachusetts is located along the Connecticut River approximately 12 miles north of Springfield and 90 west of Boston. In the flat, easternmost portion of Holyoke nearest the river were the tenements built to house the workers.

These lower wards were characterized by inadequate housing, poor sanitation and overcrowding. These conditions, combined with the minimal wages which impoverished their residents, led to significant health problems. In 1910, for example, 85% of the city's infant mortality occurred in Wards 1, 2, and 4, where housing conditions were the worst.

The French-Canadians and Irish who once inhabited the inner-city flats have been largely replaced by the Puerto Ricans. By 1990, Latinos comprised 31.1% of the city's population; close to 60% lived at or below the poverty line.

Across ethnic groups, Holyoke has one of the

highest rates of poverty in Massachusetts. 49.6% of the city's children below the age of five are from families living below the poverty level. This figure jumps to 70.7% for children of Latino origin.

Prenatal Care: The Clinic Model

From 1977 to 1981 Holyoke had the highest infant mortality rate in Massachusetts. In 1980 it had the second highest fertility rate among teenagers (14-17 years.) In 1982 only 61% of those who gave birth received adequate prenatal care, compared to 82% in Massachusetts as a whole.

The only city clinic providing prenatal care in 1980 was operated by Providence

Hospital. Once a week, clinic patients were transported by van from their neighborhoods to the hospital auditorium, where temporary curtain cubicles were erected to provide privacy for individual visits. All patients were expected to arrive at 8:00 a.m. and await their turn for care. A social worker and a nutritionist were on hand to provide counseling and referrals. Nursing staff from the maternity unit was assigned to assist in the clinic.

Family members, children in particular, were discouraged from attending clinic sessions. One physician would see approximately 30 to 50 patients in a 2 to 3 hours period. At noon, the van would return patients to their neighborhoods. Patient problems between clinic sessions were handled in the emergency rooms of the two city hospitals or via telephone by the nursing staff of the Providence Hospital labor and delivery unit.

With the growing number of Latino women attending the prenatal clinic, language became an additional barrier to good care.

The budget cuts in social services and education have eroded many programs which were preventive in nature.

The Infant Mortality Task Force

The Massachusetts Department of Public Health (MDPH) and many Holyoke health care professionals were alarmed by the 1977-1981 infant mortality rate. In 1983, MDPH assigned the Western Massachusetts Health Planning Council the task of addressing this problem. In January, 1984, the Holyoke Infant Mortality Task Force was formed. The task force consisted of representatives of several private and government agencies and community physicians.

The leadership of Providence Hospital, MDPH and the Task Force redesigned the prenatal clinic. The services were moved out of the hospital and into a building in downtown Holyoke, accessible by bus or foot for the majority of the clients. This newly expanded Prenatal Center at 210 Elm Street, partially funded by a grant from MDPH, included the services of obstetricians, nurse-midwives, a full-time social worker, a nutritionist and outreach workers. Links with the Holyoke Family Planning Office and the Visiting Nurses Association were written into the grant to assure patient access to family planning services while respecting the position of Providence Hospital, a Roman Catholic Institution.

The Task Force went on to create two other programs, the Teen Clinic at Holyoke High

School, which provides health services and counseling for high school students, and the CARE Center, originally at Holyoke Hospital, which prepares pregnant and parenting teens for the GED exam and provides on-site day care for its participants.

The Providence Hospital Prenatal Center

Since 1985, the Prenatal Center has provided prenatal care in a manner fundamentally different from the original Providence Hospital Clinic. Clients are given individual appointments, with a specific provider at a specific time. A team of obstetricians and nurse-midwives (currently 3 M.D.s and 6 CNMs) perform the prenatal visits. The nurse-midwives, who provide the majority of the prenatal care, are all bilingual in Spanish and English. They provide 24-hour telephone triage for labor and other patient problems.

A bilingual, bicultural social worker is available full-time. The WIC program offers on-site intake sessions and nutritional counseling in English and Spanish. A full-time nutritionist coordinates the WIC intakes and provides dietary counseling and breastfeeding guidance as well.

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Continued on next page

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Prenatal Care In Holyoke

Continued from previous page

two staff RNs, who provide basic education in prenatal care, psychosocial assessments of each family, pregnancy test counseling, STD counseling and myriad other patient services. Early pregnancy classes and a series of classes for prepared childbirth are offered in both languages (making the Prenatal Center the site of the only childbirth classes in Spanish in the Pioneer Valley.)

In addition, specially trained professional staff provide ongoing counseling and support for women with substance abuse problems.

There is an HIV alternative test site. An outreach worker is available to follow up on missed appointments, transport women to and from medical tests and other procedures, and reach out to patients who have no telephone and need follow up.

The Prenatal Center has become a community service to which patients can come with a variety of problems and concerns during their pregnancies. These families, whose lives are often complicated by poverty, inadequate housing, inability to speak English well, lack of transportation, unstable relationships, substance abuse and domestic violence, have turned to the Prenatal Center staff for guidance as well as care.

The Patient Population, 1985-1992

The number of patients seen at the Prenatal Center has remained roughly the same during the seven years of its existence. Approximately 700 patients enter the program each year. Around 10% are transferred to Baystate Medical Center, the local tertiary care facility, with a variety of medical complications. Another 15% or so either miscarry, move out of the area, or transfer from the service for other reasons. Each year the Prenatal Center delivers approximately 500 babies; in 1990, the nurse-midwives delivered 336 of the Prenatal Center's babies.

In 1990, approximately 60% of the patients were Latina, 37% were white, 3% were black and 1% were Asian. About 41% were 19 years of age or under; 10.5% were 16 years of age and under. Almost 90% of all patients were

enrolled in either Medicaid or the Healthy Start program. Approximately 5% have private medical insurance and have chosen the Prenatal Center for their health care because they are seeking the assistance of nurse-midwives for their births.

Infant Mortality Rates And Other Trends

With five years of infant mortality statistics available since the Prenatal Center opened, a downward trend is apparent (12.4/000 in 1984 to 8.9/1000 in 1990). This decline may lead to the conclusion that the cooperative efforts of the Prenatal Center and other related community agencies are having an effect; however, caution must be used since the numbers are small.

Additionally, other healthcare issues remain serious problems despite all efforts. In 1990, the teen birth rate climbed to 23% of all births in Holyoke. The rising incidence of STDs, including AIDS, substance abuse, domestic violence and sexual abuse is alarming. Many of these health concerns are inextricably related to poverty. The budget cuts in social services and education have eroded many programs which were preventive in nature. Other factors, such as the transformation of Medicaid into a managed-care system and the deregulation of hospitals under the Health Reimbursement Law, Chapter 495, have encouraged competition rather than cooperation among local agencies.

Clearly, many tasks lie ahead in the next ten years. The United States lags behind many other less-wealthy industrialized nations in improving perinatal outcome. Nationally, issues such as poverty and health insurance for all need to be addressed. Locally, health service providers and other community groups need to work even more closely to bridge the widening gaps in services left by a declining economy.

Most importantly, we must continue to provide personalized care to pregnant women—care which is culturally sensitive, prevention oriented and accessible, and care that addresses the woman in the context of her family and her social and economic situation. ■

Christina D. Krutsky, CNM, MSN

Jane M. Frey, CNM, MSN

Nina J. Kleinberg, CNM, MSN

Hampden Committee Activities

David Chadbourne, M.D., reviews recent activities of HDMS committees.

Hampden District Medical Society held its Annual Meeting on April 20, 1993 at Storw-ton Tavern's Carriage House. 100 members and guests were in attendance. The slate of officers for 1993-1994 was voted on by the membership and formally installed. They are: Francis D. Horrigan, M.D., President; Alicia M. Ross, M.D., President-Elect; John J. Papale, M.D., Vice President; David M. Chadbourne, M.D., Secretary; Alan M. Harvey, M.D., Assistant Secretary; John R.S. Remsberg, M.D., Treasurer.

Our speaker was Dr. Deloris Williams, the Public Health Commissioner for the City of Springfield. She outlined her goals for the future and asked our membership for any help they could give.

The Medico-Religious Committee met in April and May to work out the details for their Medical Ethics Seminar scheduled for October 20, 1993. The final selection for this year's topic was chosen. It will be "Ethical Decisions—Continuation of Medical Care". Members of the committee are currently viewing a videotape on the termination of dialysis, which may be used as the case study for the program. The medical, legal and religious professions will all be represented on the panel.

The Legislative Breakfast was held on April 30, 1993 at Mercy Hospital's Deliso Center. Total attendance was 51 persons, 11 representing area legislators. Doctor Edward Bailey presented the topic dealing with "An Act Prohibiting Certain Acts Against Children." Mr. Bill Ryder, a Senior Legislative Analyst with the Massachusetts Medical Society, presented "An Act Amending Certain Sections of the Nurse Practice Act".

The Public Health Committee met in May to discuss possible ways in which they could give support to Dr. Williams, Commissioner of the Springfield Health Department. The Committee also discussed the Third Annual No Smoking

Poster Contest. Over 5,000 students from 39 cities and towns in Hampden and Hampshire Counties participated this year. The 3 runner-up posters from each participating school were on display at the Holyoke Ingleside Mall from April 25 through May 8, 1993. The winners were picked at a judging held on May 3, 1993. Those winners were honored at an Awards Ceremony at Springfield Symphony Hall on May 12th. At that time, they received U.S. Savings Bonds and certificates signed by Senator Edward M. Kennedy. The winners and their families stayed for a small reception afterwards.

On April 25, 1993, a House Calls Program on Smoking Cessation was held. Seventeen of our members, representing various specialties, appeared on Channel 22 for one hour to answer calls from the public. These physicians stayed an additional two hours off the air to field more questions. Over 700 calls were logged.

The Executive Committee met in May and June. Gregory Connolly, D.M.D., Director of the Office on Nonsmoking and Health for the Massachusetts Public Health Department, has accepted as our speaker for the September District Meeting.

The I-Loop Subcommittee of the Health Care Task Force taped their first video at Putnam High School on June 8, 1993. Doctors Andrew and Heidi Moskovitz discussed teenage pregnancy and contraception with the students under the supervision of Doctor Alonzo Sheffield. The Committee members were pleased with the taping and are anxious to see the results after editing has been completed.

An Infant Mortality Workshop was held on May 25th at the Sheraton-Springfield Monarch Place. Members of various organizations and professions gathered to discuss possible solutions to lowering infant mortality rates. Also, the Springfield Public Health Department held an Infant Mortality Summit on June 4th at Western New England College. The guest speaker was Senator Edward M. Kennedy. ■

Family Practice: A Proud Past/A Hopeful Future

Stephen J. Levine, M.D., F.A.A.F.P., practices in Holyoke and precepts medical students from the University of Massachusetts Medical School in Worcester.

Despite the trend of subspecialization which has been evident in American Medicine since early in the 20th Century, the concept of family oriented primary care medicine has managed to survive and, in fact, appears to be on the brink of a major revival. In the past few decades, FAMILY PRACTICE has developed into a fully recognized specialty. The three year residency included a defined syllabus of theory and clinical exposures leading to certification by the AMERICAN BOARD OF FAMILY PRACTICE.

In the past several years, a strong residency program in FAMILY PRACTICE at the University of Massachusetts in Worcester, has graduated a significant number of family physicians. The medical school at U. Mass. requires a six week clerkship in family medicine for all of its third year students. I have enjoyed the opportunity to serve as a clinical preceptor for some of their fine students. The students are exposed to my hospital patients including newborns at Providence Hospital and children and adults at Providence and Holyoke Hospitals. The students have seen me perform procedures such as lumbar puncture, thoracentesis, bone marrow aspiration and biopsy, placement of triple lumen catheter and endotracheal intubation. On request, I circumcise newborn males using dorsal penile nerve block. I manage my patients in CCU, ICU and on ventilators. On an outpatient basis, minor surgical procedures are

routinely made available by me including wart removal, cryotherapy, and electrodesiccation techniques, arthrocentesis, excision of skin lesions, suturing, fine needle biopsy of breast and thyroid lesions and elective sterilization by vasectomy. The office schedule generally includes a variety of patient ages, problems, and socioeconomic backgrounds. The medical

students are exposed to patients with arthritis, hypertension, diabetes, thyroid disorders, otitis media, vaginitis, acne, epilepsy, diaper rash, depression, pregnancy, malignancy, alcoholism—the full spectrum. A small percentage of these problems need further specialty consultation. Even for those students who ultimately decide on a specialty other than FAMILY PRACTICE, the rotation serves as an eye

opener as to the life of a practitioner of the broadest of the primary care specialties.

Throughout the nation, departments of FAMILY PRACTICE are being organized to assist in appropriately credentialing and assuring the quality of care provided by FAMILY PRACTICE specialists. At Providence and Holyoke Hospitals, the medicine department include internists as well as family and general practitioners. The emergency departments include emergency medicine specialists as well as family practitioners and internists. The pediatric departments include pediatricians and family practitioners. Credentialing is based on training and demonstrated experience at both hospitals. For this reason, I have felt no need to lobby for an independent FAMILY PRACTICE DEPARTMENT. Indeed, for the past few years, I have served as Chairman of the Department of Medicine at Providence Hospital.

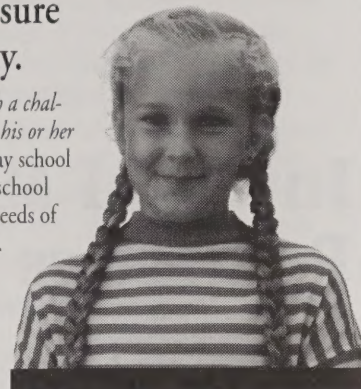
Family Practice is built on a strong foundation of tradition, is holistic in concept, and is a practical and efficient approach to health care delivery.

All that we hear about possible health care reform options suggests that emphasis will be placed on further development of primary care practitioner models with gatekeeper roles such as we've begun to experience in the HMO insurance plans locally. The specialty of FAMILY PRACTICE is often highlighted because it is holistic, facilitates a centralized family medical data base, and allows the convenience of "one stop" visits for multiple family members. It is felt likely that some economic incentives will be put in place to encourage increased numbers of primary care specialists. Currently family practice residencies are in the process of being developed at the three Boston area medical schools.

In summary, the specialty of FAMILY PRACTICE is built on a strong foundation of tradition, is holistic in concept, and is a practical and efficient approach to health care delivery. The current political climate emphasizing cost containment measures supports a positive evolution of the role of FAMILY PRACTICE in the American Health Care System. ■

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Internal Medicine/ Pediatrics As A Career

Lynn Manfred, M.D., is program director of the Internal Medicine-Pediatrics residency at Baystate Medical Center and the Chairperson for the National Med/Peds Program Directors Association.

Combined Internal Medicine/Pediatrics residencies are a relatively new option for postgraduate medical training. While the number of programs is not large, the number of residents that match to these combined programs continues to grow every year.

History

Med/Peds programs began in the late 1970s as rotating internships and grew into residencies in their own right. Programs started at the University of North Carolina at Chapel Hill and at the University of Rochester as well as at near-by Boston University. By 1980, there were fifteen programs spread throughout the country. These programs were as diverse in educational content as they were in geography. Some lasted five years, some lasted four years. Today each of the 83 programs in the United States is a four year program that leads to board-eligibility in both Internal Medicine and Pediatrics.

A real turning point for the combined residencies came in 1987, when Richard Reiselbach, then president of the Association of Program Directors in Internal Medicine, called the first meeting of the program directors of these programs. Out of that meeting came a document, ultimately approved by both the American Board of Internal Medicine and the American Board of Pediatrics that supported the concept of the combined programs and set guidelines for these programs.

Med/Peds Programs

Today, there are Med/Peds programs in 83 different institutions. They are considered tracks within the Internal Medicine and within the Pediatrics residencies. Thus, there can not be a Med/Peds residency in an institution that does not have both parent residencies. Each resident receives twenty-four months of "the core

elements" of both the internal medicine and the pediatrics residencies. They are required to have training on the inpatient services for both adults and children, in adolescent medicine, geriatrics, normal newborn care, intensive care of adults and children and

neonates. They must have outpatient training in both internal medicine and pediatrics for the entire four years of residency.

One might expect that there are a number of residents that move in and out of these combined residencies. While this is true at some institutions, by and large, the number that change in and out is about the same percentage as in the parent residency programs.

Graduates

The question frequently arises: what does the graduate of such a program do? Graduates of these programs are found in many places. Three quarters practice primary care. Most of them are in practice with other graduates of Med/Peds programs, but some work in large group practices, or in partnerships with family practice graduates.

The remaining quarter is a very diverse group. Two thirds of them are subspecialty trained, many in fields that overlap medicine and pediatrics. Adolescent medicine, emergency medicine and infectious disease are the most

The question frequently arises: What does the graduate of such a program do?

popular subspecialties practiced. However, the remainder are in areas as diverse as rehabilitation medicine, adult cardiology, pediatric endocrinology and pulmonary. It is somewhat unusual for the med/peds trainee to select a career in one or the other specialty.

The Baystate Med/Peds Program

Started in 1983, largely due to the interest of a single student, the Baystate Med/Peds program has always enjoyed the support of the Departments of Medicine and Pediatrics. This strong support has allowed Baystate to establish one of the new full-time, combined continuity clinics in the nation for its residents, and hire more Med/Peds trained faculty than any other institution in the United States. These features plus the strong curriculum, make the program one of the most competitive programs in existence today.

Baystates' early graduates all practiced medicine and pediatrics, often in very rural settings, such as northern Vermont, Montana and eastern California. More recently, one or two graduates per year have chosen to subspecialize,

in nephrology, endocrinology or infectious diseases. A few have moved to academic careers and Emergency Medicine.

Recently, the program has grown from four to six residents per year. The program continues to evolve its curriculum and improve its ambulatory teaching facilities. These steady changes help the program to keep its position of excellence on the national level. Currently, Lynn Manfred, its first Med/Ped trained director, is the Chairperson for the National Med/Peds Program Directors Association.

The Future Of Med/Peds

Med/Peds continues to grow as a career choice for medical students. Both the American Board of Pediatrics and the American Board of Internal Medicine note that graduates of these programs pursue combined careers. Thus, Med/Peds seems here to stay, perhaps as a prototype for many of the other combined residencies that are springing up nationally, for example, internal medicine-emergency medicine, internal medicine-psychiatry, pediatrics-psychiatry, etc. ■

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The Medwatch

The following describes a recent initiative of the Food and Drug Administration.

The Food and Drug Administration announced a program to improve the safety of drugs, and other regulated products by encouraging health professionals to report serious adverse events and product defects.

MEDWatch is a comprehensive approach to FDA's post-marketing surveillance and is aimed at more involvement by health professionals and better focus of their reporting.

Clinical trials that precede product approval typically include safety data on several hundred or several thousand patients. Once on the market, the much wider use of the drug or medical device occasionally brings out additional data on the safety and efficacy of the product that can have a bearing on its use. The purpose of MEDWatch is to bring this information to FDA's

attention as soon as it is gathered by health care professionals.

"MEDWatch is not just a new FDA system; it is a way of making reporting of adverse events and product problems a part of the culture of health care providers," said FDA Commissioner David A. Kessler, M.D. "Physicians, nurses and others who care for patients are the first to know when a drug or medical device does not perform as it

should. The sooner they report it to the FDA, the faster the agency can analyze the problem and take corrective action."

As part of MEDWatch, the agency has developed several ways to make it easier for health professionals to report adverse events involving almost all regulated products. Concerns with vaccines will continue to be reported separately through the Vaccine Adverse Events Reporting System.

An important part of MEDWatch is a simplified

Medwatch is... a way of making reporting of adverse events... a part of the culture of health care providers.

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reporting form that replaces five other forms previously issued for the same products.

The self-addressed, one-page form, which can be folded and mailed postage-free, will be made widely available in several publications, including the Physicians' Desk Reference, the FDA Medical Bulletin and AMA Drug Evaluations.

In addition, the agency has established for adverse event information a special 24-hour, 7-day-a-week toll-free telephone line. Health professionals will also be able to make their reports electronically by computer.

FDA keeps track of the performance of drugs, biologics and medical devices on the basis of mandatory reports—from manufacturers and device distributors and user facilities—and voluntary reporting by health care professionals.

FDA has repeatedly identified side effects that did not emerge during the clinical trials of drugs. However, in a typical year fewer than one-third of all adverse drug reaction reports and fewer than one-half of medical device problems reported to FDA involve serious patient outcomes. Moreover, a survey has indicated that as many as 50 percent of physicians are not aware of FDA's adverse events reporting system.

To encourage maximum participation in the program, the agency will hold next year a special conference on medication—and device-induced problems for academics and practitioners. FDA will also make a sustained effort to keep health professionals informed about the use of their MEDWatch reports, and it will encourage medical, pharmacy, dental and nursing schools to include in their curricula lectures on adverse event and product problem recognition and reporting.

Adverse event that should be reported include the patient's death, life-threatening illness or injury, hospitalization, disability, congenital anomaly and experiences that required intervention to prevent permanent impairment of health. MEDWatch also needs to be informed about suspected contamination, questionable stability, defective components and poor packaging or labeling of regulated products. ■



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We are pleased
to announce that

Jeanne Rabin, M.D.

has joined the full time faculty of the Department of Obstetrics & Gynecology at Baystate Medical Center, and is a member of the Baystate Medical Education and Research Foundation. In addition to her clinical practice, Dr. Rabin's area of concentration will be in the subspecialty of Urogynecology, including:

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Dr. Rabin received her medical degree from the University of Massachusetts Medical School, completed an internship in Ob/Gyn at McGill University in Montreal, and residency training in Ob/Gyn at McGill University and Case Western Reserve University. She is Board Certified, serves on the faculty of Tufts University School of Medicine, is a member of the American Urogynecologic Society, and is the director of Urogynecology Services, Department of Obstetrics and Gynecology, at Baystate Medical Center.

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Integrating Mental Health Into Primary Care Through On-Site Counseling

A nationwide survey which revealed that 22.6% of patients utilizing family physicians had mental health problems would probably not surprise most primary care physicians (Orleans, George, Houpt, Brodie, 1985). This same study further revealed that only 16% of patients identified with psychosocial problems were referred for therapy outside the practice. Additional studies indicate that as many as 75% of those patients actually referred for mental health services outside the primary care practice failed to show up for their first appointment (Rosenberg, 1976)

With the dual purpose of helping patients who need counseling services and to refer them expeditiously, I am creating a panel of mental health professionals with different areas of expertise in my family medical practice. This panel includes a psychiatrist, clinical social workers, psychologists and a psychiatric clinical nurse specialist who are able to address problems related to mental illness, substance abuse, bereavement, domestic violence, learning problems among children, social adjustment problems

related to adolescence, eating disorders and a range of other psychosocial problems that individuals encounter in their lives. They are also prepared to address problems related to non-compliance with medical treatment and the personal and family stress engendered by chronic physical illness. As a panel of qualified mental health professionals familiar with primary care medicine they are also able to accept referrals and work collaboratively with other primary care physicians in the community.

This model of having onsite psychosocial services is taught in theory in many pediatric, family practice and internal medicine residencies. It has been used for many years by Dr. Glen Aukerman, Past President of the American Academy of Family physicians, in his office in Jackson Center, Ohio. (Thorne, 1993) The concept is not unlike that of a multispecialty group or a primary care practice with on site diabetic teaching, parent education or dietary counseling services. The patients benefit from the convenience and the assurance that their referral

Continued on next page



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Integrating Mental Health

Continued from previous page

is a coordinated effort by qualified medical and mental health professionals who are interested in treating the "whole person" and not a variety of isolated symptoms. This model of interdisciplinary collaboration also benefits the overburdened primary care physician by providing ready access for referral. The physician is able to concentrate on medical management and address the psychosocial needs of the patient in a purposeful manner.

An example of this comes to mind with a recent patient who presented at my medical practice requesting a physical examination. However, as the examination proceeded he began to relate a long story about legal and family problems related to excessive marijuana use, a recent arrest for driving under the influence of drugs and a dysfunctional family situation. I made a referral for an on-site psychosocial evaluation and he received short term psychotherapy that included linkage with appropriate community resources and one medical follow up visit with me. A second patient presented with a medical complaint but behaved in a manner which clearly indicated psychiatric pathology. This individual was extremely demanding of medical time and attention and also acted in a persistent and inappropriate manner with office management personnel. She was able to receive an on-site psychiatric evaluation for her emotional problems. Consequently, her medical and mental health management became a coordinated treatment plan which she was able to respond to and utilize effectively.

When a physician becomes receptive to screening for psychosocial problems in primary care certain guidelines must be adhered to. Otherwise, we are likely to become overwhelmed with complicated personal issues from the vast numbers of our patients who have psychosocial problems. This presents a dilemma for us because a comprehensive pediatric history should include questions about a child's family, school performance and relations with peers. Similarly, an adult history includes questions related to family life, substance abuse, sexual abuse and history of depression and anxiety. Therefore, if the social history is to be thoroughly addressed a system of triage and commitment on the part of the patient is essential.

If the chief complaint is medical but the history reveals a psychosocial issue, I directly address this and invite the patient to make an appointment with one of my mental health col-

leagues. If the patient is reluctant to accept this referral I invite them to return for one additional visit with me to further discuss the psychosocial problem. At the follow up visit if I do not feel this is a self-limited problem—or one I feel comfortable handling—they will again be encouraged to accept a referral. If they refuse then future visits will deal with strictly medical issues and I will defer any further discussion with them concerning psychosocial issues until they're willing to reconsider a referral.

Discussion and identification of psychosocial problems should be anticipated and incorporated into routine office visits similar to time spent on ancillary medical procedures. The patients come to understand from the initial visit that their physician is interested in their lives but will address problems in a way that is appropriate and non-disruptive to the medical practice. With the availability of on-site referrals and services these types of cases would have easy access to mental health services. Additionally, the primary care physician enjoys an opportunity to expand the scope of capabilities by offering encouragement and non-medical assistance to the patient with chronic illness, emotional problems, and sometimes even to families of deceased patients who may need bereavement counseling.

In summary, primary care medicine includes attention to the patient as a person—an individual who is a member of a family and a community. It is not a medical specialty concerned only with medical diagnosis. A system in which the majority of patients with psychosocial problems are either left with unrecognized and unaddressed emotional pain and/or lost to follow up is limited at best. We, as primary care physicians, are in a position to do better. Incorporating mental health professionals as interdisciplinary colleagues into primary care practice has the potential to improve the quality of life for many of our patients as well as relieve the physician burden of managing difficult cases alone. ■

*Martin Lesser, D.O.
Diplomate, American Board of Family Practice
Holyoke, MA*

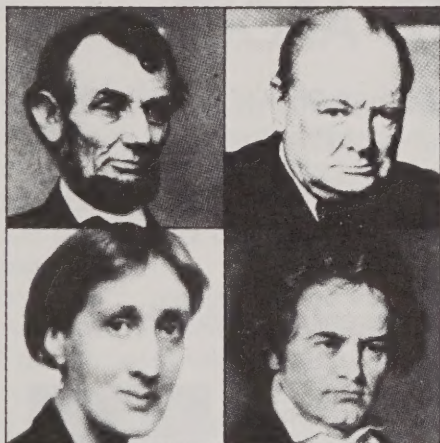
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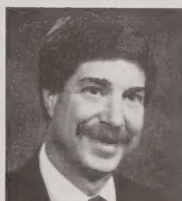
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Letters To Hilary

The following is another example of what happens when our readers fail to contribute substantive articles.

In this open forum, the First Lady answers questions about the new health plan.

Dear Hilary:

My nose is entirely too large. Being jobless and having a demanding cocaine habit, I find myself spending more money than I really need to dust the entire inside of my nose. The plastic surgeon I saw would not operate because medicaid would not pay for the operation.

I hope you will make sure that the new health program will cover these operations.

Stoned in Stony Brook

Dear Stoned:

Of course the new health program will cover these operations! Only a Republican could be so heartless. I sympathize totally with you. When I was young I could not find anyone to unbuck my teeth, and I ended up marrying far beneath my station.

Dear Hilary:

I read that under the new health plan, there will be rationing. How will this work?

Perplexed in Peoria

Dear Perplexed:

We are considering three alternatives for rationing.

- A. Every month, computers will change which services will be covered. Physicians and hospitals will not know, however, until they submit bills which are rejected. This would guarantee that rationing would not be felt by voters.
- B. Benefits for everyone over the age of 70 or who had a teminal illness would be limited to morphine for pain. Unless of course he/she could prove membership in Congress.
- C. Only politically correct diseases such as AIDS, ovarian cancer, mental illness, and termination of pregnancy would be completely reimbursed. Politically incorrect illnesses, such as gall bladder disease, childbirth, and cataracts would not be covered. Politically neutral diseases would be reimbursed 80% of charges.

Dear Hilary:

What about the obscene profits of the drug companies?

Elipsis in Evanston

Dear Elipsis:

I am furious at the way the drug companies take advantage of the consumer, and you can be sure that the new health plan will severely curtail...

Dear Hilary:

Excuse me for inturrupting but the Pharmaceutical Industry PAC has just pledged 10,000,000 towards our next campaign.

Bill

Dear Elipsis:

... Where was I? Oh. Actually, the drug companies are engines of prosperity, with remarkably enlightened leadership, a positive trade balance, and profits which truly do not seem out of line compared with, for example, Caesar's Palace in Las Vegas.

Dear Hilary:

It has been estimated that the cost of malpractice insurance, the cost of defensive medicine, and the cost of defending against frivolous malpractice cases all contribute about 25% to the total cost of health care. What are you going to do about that?

Orthopod in Ohio

Dear Orthopod:

As a lawyer, I am well aware of the malpractice situation. The new health care plan will make it a federal crime to practice defensive medicine, and the justice department will vigorously prosecute every such suspect. As for frivolous malpractice cases, we will greatly reduce those by requiring that the defendant pay for the entire trial, whether or not he/she wins or loses. This will encourage more out of court settlements and far fewer court cases.

To reduce the cost of malpractice insurance, the new health care plan will suggest that malpractice premiums be paid for with *Discover* cards, which will provide for a reimbursement of up to 1% annually.

Continued on next page

Letters To Hilary

Continued from previous page

Dear Hilary:

If your plan becomes law, what would you do if you had a politically incorrect disease, or a terminal disease, or were over seventy, and wanted decent health care?

Disgruntled in Denver

Dear Disgruntled:

Lets look at it this way. The average wealthy person in the former Soviet Union has about the same purchasing power as one of our working poor. When they want decent medical care, they go to Hungary, or Czechoslovakia, or some other European country where all the physicians were trained in the United States, France, or Great Britain. I think we Americans can learn to do the same.

Dear Hilary:

I recently read that garlic lowers blood pressure, lowers cholesterol, reduces arteriosclerosis, prevents cancer, and heals ulcers. Why don't you make that part of your health plan? Just make a law saying that all food and drink sold in the United States contain garlic?

Gleeful in Gilroy

Dear Gleeful:

How are things out there in the Garlic Capital of the World? Your suggestion is great! I started taking garlic right after Chelsea was born. For the career woman uninterested in pregnancy, it seems to work very well also.

Dear Hilary:

Ever since I was a small boy, I've been sexually attracted to other males. I really don't like being this way, and want to get psychiatric help. Will your new health care bill cover this kind of thing?

Gay in Glenbrook

Dear Gay:

Being gay is not an illness. Of course the new health care plan won't cover perfectly normal and politically correct conditions!

Dear Hilary:

Our little hospital serves a rural farming community of 12,000 people, and is at 95% occupancy. We cut corners and pinch pennies, we lay off people and delay needed maintenance, we buy everything we can from Walmart, but still we continue to lose money. Soon we will have to close our hospital. Will the new health care plan help us?

Whipped in Whistlestop

Dear Whipped:

We can no longer, as a nation, afford to support your kind of hospital. Much greater efficiencies can be achieved by concentrating health care in a few large regional centers. The health care plan is committed to making sure that no American is more than six hours away from one of these centers, which will, of course, be located in major metropolitan areas. Which generally vote Democratic, unlike some rural farming communities I could name, but that, of course has nothing to do with our decision.

Dear Hilary:

This is off the subject, but is it true that Bill is not too bright, has no principles, has vicious mood swings, is extremely vindictive, drinks out of the toilet, and is overweight?

Al and Tipper

Dear Al and Tipper:

Those names sound vaguely familiar! As for your question, a lot depends on how you define "overweight". By my definition, I'd have to say that the above statement is untrue. ■

New Members Welcome

Carolyn E. Brooks, M.D.
Providence Hospital
1233 Main Street
Holyoke, MA 01040

Born: July 22, 1957
Premed: Dartmouth College 1975-1978
Medical: Dartmouth Medical School, New Hampshire 1979-1982
Internship: Kennebec Valley Medical Center, Maine 1982-1983
Residency: Kennebec Valley Medical Center 1983-1984
Baystate Medical Center 1987-1991
Specialty: Radiology

William F. Pekruhn, III, M.D.
444 Montgomery Street
Chicopee, MA 01020

Born: October 8, 1948
Premed: Yale College 1967-1971
Medical: University of Pittsburgh, PA 1971-1975
Internship: St. Margaret Hospital, Pittsburgh, PA 1975-1976
Residency: University of Pittsburgh, PA 1979-1982 (Dermatology)
Specialty: Dermatology

Theodore J. Krawiec, M.D.
75 Springfield Road
Westfield, MA 01085

Born: February 5, 1938
Premed: University of Notre Dame 1955-1959
University of Massachusetts 1965-1966
Medical: New Jersey College of Medicine 1966-1970
Internship: New Jersey College of Medicine 1970-1971
Residency: New Jersey College of Medicine 1971-1974
Specialty: Ophthalmology

Andrew S. Wetstone, M.D.
46 Daggett Drive
West Springfield, MA 01089

Born: October 30, 1961
Premed: Tulane University, New Orleans 1980-1984
Medical: Tulane University School of Medicine 1985-1989
Internship: Baystate Medical Center, 1989-1990
Residency: Baystate Medical Center, 1990-1992
Specialty: Internal Medicine

Daniel P. DeFlorio, M.D.
Life Laboratories
299 Carew Street
Springfield, MA 01104

Born: August 19, 1950
Premed: Boston College, MA 1968-1972
Medical: University of Massachusetts Medical School 1972-1976
Internship: Mallory Institute of Pathology-Boston City Hospital 1976-1977
Residency: Boston City Hospital 1977-1978 (Senior Resident-Pathology)
UMass Medical Center 1978-1979 (Chief Resident-AP)
Worcester Memorial Hospital 1979-1981 (Clinical Pathology Resident & Chief Resident-AP & CP)
Fellowship: University of Massachusetts (Research as Medical Student)
Specialty: Atomic and Clinical Pathology

David E. Artzerounian, M.D.
Holyoke Hospital
575 Beech Street
Holyoke, MA 01040

Born: December 20, 1947
Premed: University of Virginia 1965-1969
Medical: Hahnemann University 1970-1974
Residency: Baystate Medical Center 1974-1977
Specialty: Occupational Medicine/Internal Medicine

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Knowing that I'll get a call about them late at night.
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Zap out the order, try again, until I get it right.
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using PCIS.
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John Keats, M.D.

- * pronounced "psis" for the sake of the meter.
** normally pronounced "piggy", but for the sake of
rhyme it is pronounced "paGYE" here.

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